DEPARTMENT OF MENTAL HEALTH/MENTAL RETARDATION SERVICES
Frankfort, Kentucky

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

DATE OF REQUEST: _____

CONSUMER NAME: _____ DOB: _____
ADDRESS: _____
MEDICAL RECORD NUMBER: _____

ADDRESS TO SEND DISCLOSURE ACCOUNTING (if different from above):
_____

DATES REQUESTED:
I would like an accounting of all disclosures for the following time frame:
(Please note: the maximum time frame that can be requested is six years prior to the date of request, but not before __/__/__ {**Insert the implementation date of your institution's *Accounting of Disclosure Policy***}.

From: _____ To: _____

Fees:
First request in a 12-month period Free
Subsequent Requests: $_____ **(Insert cost based fee per entity)**

The fee for this request will be: _____

I understand that there is a fee for this accounting and wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

_____ _____
Signature of Consumer or Legal Representative Date

For Department Use Only:
Date Received: _____ Date Sent: _____
Extension Requested: No Yes, Reason _____
Consumer notified in writing on this date: _____
Verification of Identity of individual and/or legal representative obtained/filed: _____
_____
Staff member processing request: _____

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